PART II

INFORMATIONAL MANUAL
TEFRA/KATIE BECKETT DEEMING WAIVER

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE

July 1, 2006

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I. TEFRA/KATIE BECKETT MEDICAID COVERAGE (ALSO KNOWN AS DEEMING WAIVER)

A. Background

The Department of Community Health provides Medicaid benefits under the TEFRA/Katie Beckett Medicaid program as provided under §134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248). States are allowed, at their option, to make Medicaid benefits available to children (age 18 or under) at home who qualify as disabled individuals under §1614(a) of the Social Security Act provided certain conditions are met, even though these children would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of the deeming of parental income or resources. The specific statutory provisions establishing this option are contained in §1902(e) of the Social Security Act.

In order for a child to establish Medicaid eligibility under this program, it must be determined that:

- If the child was in a medical institution, he/she would be eligible for medical assistance under the State plan for title XIX;
- The child requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the mentally retarded);
- It is appropriate to provide the care to the child at home; and
- The estimated cost of caring for the child outside of the institution will not exceed the estimated cost of treating the child within the institution.

The Department has taken a look at its procedure for determining which children qualify medically for the TEFRA/Katie Beckett coverage. A sub-committee comprised of legal, clinical, and eligibility staff met over several months to revise the criteria used in making the medical necessity and level of care determinations.

In the past, the medical criteria used for adults were used for children as well. The criteria used to determine a child's eligibility in the program is found in Title 42 Code of Federal Regulations. Medical necessity is **not** based on specific medical diagnoses. The reviewer must review all available medical information to determine whether services are medically necessary. In addition, the reviewer must determine whether the child requires the level of care provided in a hospital, nursing facility, or intermediate care facility (including an intermediate care facility for the mentally retarded). DCH has developed standardized forms to be used in obtaining the information needed for the disability, level of care, and cost effectiveness determinations. Georgia Medical Care Foundation (the vendor

responsible for making the level of care determinations), and the Division of Family and Children Services are trained on the criteria.

The criteria will be used for all applications filed on or after **November 15, 2004**. For children currently eligible as of **November 2004**, the criteria will be used at the next annual redetermination of eligibility. This means that if the child's annual redetermination is due in December 2004; the child's continued eligibility will be reviewed using the new criteria. Once the child's case has been reviewed using the new criteria, and if the parent is not satisfied with the action taken regarding the level of care, they will have the right to request a hearing by contacting DCH Legal Services.

B. What is TEFRA/"Katie Beckett"?

TEFRA is section 134 of the **T**ax **E**quity and **F**iscal **R**esponsibility Act of 1982 (TEFRA) allowing states to make Medicaid services available to certain disabled children who would not ordinarily be eligible for Social Security Income (SSI) benefits because of their parents' income. Income qualifications for TEFRA/"Katie Beckett" are based solely on the child's income, but a number of different factors are considered for approval. If approved, the same eligibility for health coverage will be available to the child as other Medicaid members.

1. Eligibility for Medicaid under TEFRA/"Katie Beckett" will only be approved if **ALL** of the following conditions are met:

    - Child is 18 years of age or younger.
    - Child meets the federal criteria for childhood disability.
    - Child meets an institutional level of care criteria.
    - Even though the child may qualify for institutional care, it is appropriate to care for the child at home.
    - The Medicaid cost of caring for the child at home does not exceed the Medicaid cost of appropriate institutional care.

The childhood disability determination is completed by the Department of Human Resources State Medical Review Team.

The child must require institutional level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded as defined in 42 C.F.R. 435.225(b) (1).

The child's physician is required to certify that it is appropriate to provide care for the child in the home setting. The Medicaid cost of caring for the child at home must be less than it would be to care for the child in whichever type of institution's level of care was met. DFACS will be responsible for the cost-effective determination task.

After a thorough review of TEFRA, non-compliance with federal regulations became apparent to the Department of Community Health (DCH) and therefore necessary changes were implemented. The DCH moved in the direction of enforcing the C.F.R. for TEFRA to become compliant with federal policy.

C. Policy and Procedural Changes

1. No procedural changes were made in the categorical eligibility determination section.

2. Level of Care Determinations

   The Georgia Health Partnership (GHP) – Georgia Medical Care Foundation (GMCF) determines whether the child requires a level of care (LOC) provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the mentally retarded) for the TEFRA/Katie Beckett Medical program. The Department developed a new DMA-6 form specifically for children – *Pediatric DMA-6A, PHYSICIAN'S RECOMMENDATION CONCERNING NURSING FACILITY CARE OR HOSPITAL CARE (Pediatric DMA-6A).* ACS stocks the form DMA-6A, but for now, the form must be reproduced locally. The Department is also working on making the form an interactive form in the GHP web portal.

   In order to make the LOC determination, the DFCS case worker must submit a **complete packet** of documents to GMCF. A complete packet consists of the Pediatric DMA-6A, Care Plan, Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), and Psychological Evaluation, if necessary. The following documents must be completed and submitted to GMCF as part of the LOC determination: in most cases, the family will be responsible for submitting this information to DFCS. However, there may be instances when the DFCS case worker must assist the family in obtaining the necessary information.

3. Application Requirements for LOC Review

   - Pediatric DMA-6A Form

     The Pediatric DMA-6A form has been developed to appropriately capture pertinent information regarding the medical needs and care of the child. The DMA-6A form must be completed in **its entirety**, signed and dated by the physician and parent prior to being submitted to GMCF. The 30 day period of validity has been changed to 90 days.

Instructions for completion of the DMA-6A form are included in this manual (refer to the appendices). The DMA-6A form must be completed at application, and at the annual redetermination of eligibility. Clinical information obtained from the DMA-6A is used in the assessment to determine level of care.

- Care Plan

  The Care Plan form must be completed, signed and dated by the **physician, and the primary caregiver** at a minimum. Other members of the planning team may participate in the completion of this form. The planning team may include, but is not limited to, the child's primary and secondary caregivers, physician, nursing provider, social worker, and therapist(s) (i.e., physical, occupational, speech). A copy of the Care Plan and instructions are included in this manual (refer to the appendices). A current care plan must be completed at application, and at the annual redetermination of eligibility.

- Psychological Assessment

  An evaluation is performed by a licensed certified professional to assess the child's level of intellectual capacity. If the child has a diagnosis or condition that results with cognitive impairment, a psychological or developmental assessment should be requested by the Georgia Medical Care Foundation (GMCF). The following diagnoses require a psychological or developmental assessment:

  - Cerebral Palsy
  - Developmental Delay
  - Autism
  - Pervasive Developmental Disorder
  - Mental Retardation
  - Epilepsy
  - Down's Syndrome, and
  - Any diagnoses related to the above listed diagnoses.

  A comprehensive psychological evaluation must be performed and the level of mental retardation with appropriate treatment intervention must be stated. It must be done by a licensed clinical psychologist and is required for every three (3) years. Also an Individualized Family Service Plan (IFSP) or an Individualized Education Plan (IEP) is required, if performed. All of the above documents and psychological assessment can be utilized to determine level of care.

II. INSTITUTIONAL LEVEL OF CARE (LOC) CRITERIA

As provided in 42 C.F.R 435.225(b) (1), the child must require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR).

A. Nursing Facility

1. Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*. With respect to an individual who has a mental illness or mental retardation, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

2. The criteria set forth herein encompass both "skilled" and "intermediate" levels of care services.

3. A nursing facility level of care is indicated if all the conditions of Column A or Column B are satisfied in addition to all the conditions of Column C being satisfied. Conditions are derived from 42 C.F.R.409.31 – 409.34.

B. Intermediate Care Facility (ICF/MR)

1. ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.

2. An ICF/MR level of care is indicated if one condition of Column A is satisfied in addition to all the conditions Column B and Column C being satisfied. Conditions derived from 42 C.F.R. 440.150, 435.1009, and 483.440(a).

C. Hospital

1. Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases.

2. A hospital level of care is indicated if all the conditions of Column A, Column B, and Column C are satisfied. Conditions derived from 42 C.F.R 440.10.

3. As derived from 42 C.F.R. 440.10, the child requires the type of care ordinarily furnished in a hospital for the care and treatment of inpatients, other than that for mental diseases, under the direction of a physician or dentist. Hospital level of care screen: This is a new responsibility as far as Katie Beckett is concerned. GMCF will review if clinical information provided meets Pediatric Interqual criteria. The responsibility is identical to the pre-certification process on behalf of adults. The review is to be done at the time of initial application, and for children who qualified by meeting the hospital level of care, every thirty days thereafter.

D. Level of Care Determination Routing Form

The Level of Care Determination ***Routing Form 705*** must accompany **all** the child's information and documents submitted to GMCF. It is imperative that identifying information such as social security number and Medicaid identification remain consistent whenever communicating with GMCF. This will help them track all information for the child.

E. Cost-Effectiveness Determination

It must be determined that the estimated Medicaid cost of caring for the child outside the institution does not exceed the estimated Medicaid cost of appropriate institutional care. The Physician's Referral Form is being replaced with the **TEFRA/Katie Beckett Cost-Effectiveness Form-704**. The revised form includes places for the physician to include the estimated cost for therapy(s) and skilled nursing services. The Department is trying to establish a process for providing the actual cost of services provided to a child to be used at the annual redetermination for this process. However, until the process has been established, workers will continue to use the TEFRA/Katie Beckett Cost-Effectiveness Form-704 at the initial application and the annual redetermination of eligibility for completion of the cost-effectiveness determination.

Until the Department provides an amount to be used for the hospital level-of-care-cost-effective determination, please have workers submit the completed form DMA-704 to:

Division of Medical Assistance
Attention: Eligibility/Recipient Unit
Department of Community Health
2 Peachtree Street, NW-39th Floor
Atlanta, GA 30303

A copy of the TEFRA/Katie Beckett LOC Routing Form 705 must be attached when submitting Form DMA-704 to the Department.

The amounts listed below are the averaged amounts to be used for completion of the nursing facility and ICF/MR level-of-care-cost effectiveness determination.

Level-of-Care	**Monthly Amount (averaged Medicaid rates)**
▪ Skilled Nursing Facility	$3,645.00
▪ ICF/MR	$6,667.00

III. HEARING AND APPEALS PROCESS

Due process rights associated with the denial of admission to the "Katie Beckett" program are initially commenced **after the level of care assessment** by GMCF. Participants in the "Katie Beckett" program are subject to yearly assessments by GMCF. Should the level of care assessment result in the denial of admission/continuation into the Katie Beckett program, GMCF will forward an "Initial Denial of Admission/Continued Stay" to the family (with a copy to the DFCS case worker). This notice informs the parents of the reason for the denial and the administrative review rights.

The Division offers the opportunity for administrative review to any applicant or recipient against whom it proposes to take an adverse action unless otherwise authorized by law to take such action without having to do so. Parents may request an administrative review of the level of care assessment within thirty (30) days "Initial Denial of Admission/Continued Stay". The request must include all relevant issues in controversy and must be accompanied by any additional medical information and explanation that the applicant or recipient wishes the Division to consider. The additional documentation will be considered to determine the appropriateness of the initial denial. Georgia Medical Care Foundation personnel should instruct parents to supply the additional documentation to GMCF for consideration during the administrative review process. If the parent fails to request an administrative review or if the parent fails to submit additional documentation, the initial denial will become final on the 30th day after the date of the "Initial Denial of Admission/Continued Stay".

The Georgia Medical Care Foundation must *receive* requests for administrative review within the 30 day time limit. When counting days, allow the parents a two (2) day time period for receipt of the letter. Then, beginning on the third day after the date of the letter, regardless of whether that day is a weekend or holiday, count 30 days. However, if the 30th day falls on a weekend or holiday, **the next full business day is counted as the 30th day**.

Upon completion of the Administrative Review, GMCF will notify the parents (with a copy to the DFCS case worker) of the results of the review. Should GMCF uphold the initial decision and the family fails to request an administrative review or fails to submit additional documentation, then a "Final Denial of Admission/Continued Stay" letter is sent to the parents (with a copy to the DFCS case worker). This notice informs the parents of the reason for the denial and their hearing rights. The Legal Services Section of DCH should receive a parent's request for a hearing (and continuation of services, if applicable) before an administrative law judge within thirty (30) days from the date of the "Final Denial of Admission/Continued Stay" letter. The hearing request should state the specific reasons for requesting the hearing. Parents should also state whether they would like a continuation of services pending the outcome of the hearing. This option is only available for those members requesting continued stay in the program. However, these members must be cautioned that should it prevail, the Division will seek reimbursement for services rendered during the appeals period. Additionally parents

should be instructed to include a copy of the "Final Denial of Admission/Continued Stay" letter with their hearing request.

After receiving the hearing request, Legal Services will email a request for documentation to GMCF and ACS legal counsel. Legal Services will also notify the Eligibility Section of a parent's request for a continuation of services. Upon receiving the file from GMCF, Legal Services will prepare the file to be assigned to an attorney and forward the appropriate documentation to the Office of State Administrative Hearings for scheduling. Files submitted to Legal Services should contain, among other things, the level of care application, any additional documents submitted during the administrative review process, the initial and final determination letters, the parent's hearing request, the contact information for the DFCS case worker and the contact information for the GMCF assessor. Both the DFCS case worker and the GMCF assessor will work with the DCH attorney to prepare for the hearing. If the denial of eligibility issued by DFCS is solely based upon the level of care determination, the DFCS case worker will be required to testify regarding the denial of eligibility determination. This will prevent the need for two hearings since the denial of eligibility and the level of care determination are intertwined.

If the administrative review decision is upheld at the hearing, the parents will be notified (with a copy to the DFCS case worker). The decision should include a ruling on the denial of eligibility, if the denial was based solely upon the level of care determination. The DFCS case worker will send notice to parents of the denial of eligibility and close the case. The decision from the administrative law judge will include appeal rights for any party dissatisfied with the decision. If the Administrative Law Judge determines that the level of care criteria has been met, a written decision will be forwarded to the parent will be notified (with a copy to the DFCS case worker). At this time, the DFCS case worker will use the level of care with other information to render an eligibility decision.

A denial of eligibility based upon factors not associated with the level of care will create additional due process rights. **However, these hearings are handled by the Department of Human Resources and may occur subsequent to or concurrent with the level of care hearings.** The timing of these hearings is based upon the timing of the decision on eligibility

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing.** You must send your request for a hearing, along with a copy of the adverse action letter, within **thirty (30) days** of the date of the letter to:

Department of Community Health
Legal Services Section
Two Peachtree Street, NW - 40th Floor
Atlanta, Georgia 30303-3159

If you want to maintain your services pending the hearing decision, you must send a written request **before** the date your services change. **If this action is sustained by a hearing decision, you may be held responsible for the repayment of continued services that were provided during the appeal.**

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You maybe able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

1. **Georgia Legal Services Program**
   1-800-498-9469
   (Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. **Georgia Advocacy Office**
   1-800-537-2329
   (Statewide advocacy for persons with disabilities or mental illness)

3. **Atlanta Legal Aid**
   404-377-0701 (DeKalb/Gwinnett Counties)
   770-528-2565 (Cobb County)
   404-524-5811 (Fulton County)
   404-669-0233 (So. Fulton/Clayton)
   678-376-4545 (Gwinnett County)

4. **State Ombudsman Office**
   1-888-454-5826
   (Nursing Home or Personal Care Home)

504. Medicaid Member Administrative Law Hearings (Fair Hearings)

A. This section does not apply to PeachCare for Kids members. PeachCare for Kids members should consult Appendix D of this manual for the Review and Appeal Process.

B. Children participating in the Georgia Pediatric Program (GAPP) or the TEFRA/Katie Beckett Program shall participate in the administrative review process prior to an Administrative Law Hearing. Parents may request an administrative review within 30 days of the date the initial decision is transmitted to the parent. During the administrative review additional documentation may be considered to determine the appropriateness of the initial decision. Parents will be instructed in the initial decision letter to supply the additional documentation to the appropriate personnel at the Georgia Medical Care Foundation. If the parent fails to submit additional documentation, the initial decision will become final on the 30th day after the date of the initial decision. At the end of the administrative review, the member will be sent a notice of the Department's final decision.

C. Should the Department's decision be adverse to the member, the parent may request a hearing before an Administrative Law Judge. A hearing must be requested in writing. Members must send the request and a copy of the final decision letter, in 30 days or less from the date that the notice of action was mailed, to the following address:

Georgia Department of Community Health
Legal Services Section
Division of Medical Assistance
2 Peachtree Street, NW – 40th Floor
Atlanta, Georgia 30303-3159

D. Members may continue their services during the appeal if they submit a written request for continued services before the date that the services change. If the Administrative Law Judge rules in favor of the Division, the member will be required to reimburse the Division for the cost of any Medicaid benefits continued during the appeal.

E. The Office of State Administrative Hearings will notify the member of the time, place and date of the hearing.

505. Commissioner's Review for a Member

Should the Administrative Law Judge's decision be adverse to a member, the member may file a written request to the DCH Commissioner for an agency review within 30 days of receipt of the decision.

IV. APPENDICES

TEFRA/Katie Beckett
Level-of-Care Determination Routing Form

DATE SENT: _____

TO: GHP/GMCF
P. O. Box 7000
McRae, GA 31055-7000

FROM: **_____County DFACS**

Medicaid Worker's Name: _____
Direct
Caseload #:_____ Phone #: _____

Email address: _____

Medicaid Worker's Address: _____

_____

RE: Child's Name: _____

Child's Member ID #: _____

Child's SSN: _____

A **complete packet** must be submitted to the GHP/GMCF.

Complete packet **Additional information**

Original DMA-6A (see instructions for completion of form)
DMA Care Plan (see instructions for completion of form)
Therapy Notes, if applicable
Psychological Evaluation, if applicable
IEP or IFSP, if available

Date packet received by GMCF: _____

Type of Program: ☐ **Nursing Facility**
☐ **GAPP** ☐ **TEFRA/Katie Beckett**

PEDIATRIC DMA 6(A)
PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:

DFCS County_____

_____
Mailing Address

2. Medicaid Number:

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3. Social Security Number

4. Sex | Age | 4A. Birthdate

5. Primary Care Physician

6. Applicant's Telephone #

7. Does guardian think the applicant should be institutionalized? ☐ Yes ☐ No

8. Does child attend school? ☐ Yes ☐ No

9. Date of Medicaid Application / /

Name of Caregiver #1: _____ Name of Caregiver #2: _____

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Department of Community Health and the Department of Human Resources, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

10. Signature: _____ 11. Date:_____
(***Parent or other Legal Representative)***

Section B – Physician's Report and Recommendation

12. History: *(attach additional sheet if needed)*

	1. ICD	2. ICD	3. ICD
13. Diagnosis 1)_____ 2)_____ 3)_____ ***(Add attachment for additional diagnoses)***			

14. **Medications**				15. **Diagnostic and Treatment Procedures**	
Name	Dosage	Route	Frequency	Type	Frequency

16. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)**

Previous Hospitalizations:_____ Rehabilitative Services:_____ Other Health Services:_____

Hospital Diagnosis: 1)_____ 2) Secondary_____ 3) Other_____

17. Anticipated Dates of Hospitalization: _____/_____ / 18. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

19. Type of Recommendation:
☐ Initial
☐ Change Level of Care
☐ Continued Placement

20. Patient Transferred from (check one):
☐ Hospital ☐ Another NF
☐ Private Pay ☐ Lives at home

21. Length of Time Care Needed _____Months
1) ☐ Permanent
2) ☐ Temporary _____ estimated

22. Is patient free of communicable diseases? ☐ Yes ☐ No

23. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services

24. Physician's Name (Print):

Physician's Address (Print):

25. I certify that this patient requires the level of care provided by a nursing facility, IC/MR facility, or hospital
_____Physician's Signature

26. Date signed by Physician | 27. Physician's Licensure No. | 28. Physician's Telephone #: ( )

Section C– Evaluation of Nursing Care Needed (check appropriate box only)

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral Status
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/GT Meds	☐ Age Dependent Incontinence ☐ Incontinent - Age > 3 ☐ Colostomy ☐ Continent ☐ Other _____	☐ Monitoring ☐ CPAP/Bi-PAP) ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs > 2/day ☐ Therapy ☐ Oxygen ☐ Home Vent ☐ Trach ☐ Nebulizer Tx ☐ Suctioning ☐ Chest - Physical Tx ☐ Room Air	☐ Prosthesis ☐ Splints ☐ Unable to ambulate > 18 months old wheel chair ☐ Normal	☐ Agitated ☐ Cooperative ☐ Alert ☐ Developmental Delay ☐ Mental Retardation ☐ Behavioral Problems (please describe, if checked) ☐ Suicidal ☐ Hostile

34. Integument System	35. Urogenital	36. Surgery	37. Therapy/Visits	38. Neurological Status
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☐ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age > 3 ☐ Catheterization ☐ Continent	☐ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	Day care Services ☐ High Tech - 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 per month ☐ None	☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal

39. Other Therapy Visits
☐ Five days per week ☐ Less than 5 days per week

40. Remarks

41. Pre-Admission Certification Number

42. Date Signed

43. Print Name of MD or RN:_____

Signature of MD or RN:_____

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date:_____ Admission Date _____ Approved for _____Days or _____Months

45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution? ☐ Yes ☐ No

46A. State Authority MH & MR Screening)
Level I/II
Restricted Auth. Code Date
46B. This is not a re-admission for OBRA purposes
Restricted Auth. Code Date

47. Hospitalization Precertification ☐ Met ☐ Not Met

48. Level of Care Recommended by Contractor ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

49. Approval Period	50. Signature (Contractor) _____	51. Date / /	52. Attachments (Contractor) ☐ Yes ☐ No	

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

INSTRUCTIONS FOR COMPLETING THE PEDIATRIC CARE FORM DMA-6(A)

This section provides detailed instructions for completion of the ***Form DMA-6 (A)***. Before payment can be made, a ***Form DMA-6 (A)*** must be completed by the ***Primary Care Physician (PCP) and the parent or legal representative*** and signed by the PCP. The Form DMA-6 (A) is considered valid only if it is signed by the ***Primary Care Physician*** and dated.

Section A - Identifying Information

It is the responsibility of the responsible party to see that Section A of the form is completed with the applicant's name and address.

Item 1: **Applicant's Name and Address**
Enter the complete name and address of the applicant including the city and zip code.

The caseworker in the Department of Family and Children Services (DFCS) will complete the mailing address and county of the originating application.

Item 2: **Medicaid Number**
Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;

b. If the member or applicant was previously determined eligible by DFCS staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or

c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

The entire number must be placed on the form correctly. In exceptional instances, it may be necessary to contact the caseworker in the DFCS office for the Medicaid number.

Item 3: Social Security Number
Enter the applicant's nine-digit Social Security number.

Item 4&4A: Sex, Age and Date of birth
Enter the applicant's sex, age, and date of birth.

Item 5: **Primary Care Physician**
Enter the entire name of the Primary Care Physician (PCP).

Item 6: **Telephone Number**
Enter the telephone number including area code of the applicant's parent or the legal representative.

Item 7: **Does the parent or legal representative think the applicant should be institutionalized?**
Please check the appropriate box.

Item 8: **Does the child attend school?**
Please check the appropriate box if the member attends school.

Item 9: **Date of Medicaid Application**
Enter the date the family made application for Medicaid services.

Fields below Item 9:
Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, please indicate the name of the caregiver.

Read the statement below the name(s) of the caregiver(s) and then;

Item 10: **Signature**
The parent or legal representative for the applicant should sign the DMA-6 (A).

Item 11: **Date**
Please include the date the DMA-6 (A) was signed by the parent or the legal representative.

Section B - Physician's Examination Report and Recommendation

Item 12: **History (attach additional sheet(s) if needed)**
Describe the applicant's medical history (Hospital records may be attached).

Item 13: **Diagnosis (Add attachment(s) for additional diagnoses)**
Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor's staff will complete these boxes.

Item 14: **Medications (Add attachment(s) for additional medication(s)**
The name of all medications the applicant is to receive should be listed. Name of drugs with dosages, routes, and frequencies of administration are to be included.

Item 15: Diagnostic and Treatment Procedures
Any diagnostic or treatment procedures and frequencies should be indicated.

Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)
List previous hospitalization dates, as well as rehabilitative, and other health care services the applicant has received or currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.

Item 17: Anticipated Dates of Hospitalization
List any dates the applicant may be hospitalized in the near future for services.

Item 18: Level of Care Recommended
Recommendation regarding the level of care considered necessary. Enter a check in the correct box for hospital, nursing facility, or an intermediate care facility for the mentally retarded.

Item 19: Type of Recommendation
Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.

Item: 20: Patient Transferred from (Check one)
Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.

Item 21: Length of Time Care Needed
Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box on the length of time care is needed either permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.

Item 22: Is Patient Free of Communicable Diseases?
Enter a check in the appropriate box.

Item 23: Alternatives to Nursing Facility Placement
The admitting or attending physician must indicate whether the applicant's condition could or could not be managed by provision of the Community Care or Home Health Care Services Programs. Enter a check in the box corresponding to "could" and either/both the box (es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Enter a check in the box corresponding to "could not" if neither is appropriate.

Item 24: Physician's Name and Address
Print the admitting or attending physician's name and address in the spaces provided.

Item 25: Certification Statement of the Physician and Signature
The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. Signature stamps are not acceptable.

Item 26: Date signed by the physician
Enter the date the physician signs the form.

Item 27: Physician's Licensure Number
Enter the Georgia license number for the attending or admitting physician.

Item 28: Physician's Telephone Number
Enter the attending or admitting physician's telephone number including area code.

Section C - Evaluation of Nursing Care Needed (Check Appropriate box only)

Licensed personnel involved in the care of the applicant should complete Section C of this form.

Item 29: Nutrition
Check the appropriate box (es) regarding the nutritional needs of the applicant.

Item 30: Bowel
Check the appropriate box(es) to indicate the bowel and bladder habits of the applicant.

Item 31: Cardiopulmonary Status
Check the appropriate box (es) to indicate the cardiopulmonary status of the applicant.

Item 32: Mobility
Check the appropriate box (es) to indicate the mobility of the applicant.

Item 33: Behavioral Status
Check all appropriate boxes (es) to indicate the applicant's mental and behavioral status.

Item 34: Integument System
Check the appropriate box (es) to indicate the integument system of the applicant.

Item 35: Urogenital
Check the appropriate box (es) for the urogenital functioning of the applicant.

Item 36: Surgery
Check the appropriate box regarding the number of surgeries the applicant has had to your knowledge or obtain this information from the parent or other legal representative.

Item 37: Therapy/Visits
Check the appropriate box to indicate the amount of therapy visits the applicant receives.

Item 38: Neurological Status
Check the appropriate box(es) regarding the neurological status of the applicant.

Item 39: Other Therapy Visits
If applicable, indicate the number of treatment or therapy sessions per week the applicant receives or needs.

Item 40: Remarks
Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form or any additional comments.

Item 41: Pre-admission Certification Number
Indicate the pre-admission certification number (if applicable).

Item 42: Date Signed
Enter the date this section of the form is completed.

Item 43: **Print Name of MD or RN**
The individual completing Section C should print their name and sign the DMA-6 (A).

Do Not Write Below This Line
Items 44 through 52 are completed by Contractor staff only.

Initial Date _____

TEFRA/KATIE BECKETT WAIVER

CARE PLAN

Section A: To be completed by parent or legal representative

Personal History: _____

Applicant's Name: _____ DOB: _____Applicant's Age_____

Applicant's Address: _____

Applicant's Telephone number_____

City: _____ State: _____ Zip Code: _____ County:_____

Member's Social Security #: _____ Medicaid I.D. # _____
_____

Family History:

Mother's name: _____ Father's name:_____
Mother's educational level: _____ Father's educational level: _____
Does Primary Caregiver work? ☐ Yes ☐ No Primary Caregiver's work schedule: Hours:_____
Does Secondary Caregiver work? ☐ Yes ☐ No Secondary Caregiver's work schedule: Hours: _____
Other Siblings: Name(s) _____ _____ _____

SCHOOL SERVICES/EDUCATION:

Is Child In School? ☐ Yes ☐ No ☐ # of hours per day in school: _____ # of days per week in school: _____

Does the child have a: ☐ IFSP or an ☐ IEP? ☐ Yes ☐ No
IFSP Current? ☐ Yes ☐ No
IEP Current? ☐ Yes ☐ No
If yes, (submit with application)

Level of Care In School - Applicant's

☐ Skilled Nursing/Number of hours per day: _____

☐ Unskilled Nursing (Aide) Number of hours per day: _____

☐ Therapies: _____

Section B: To be completed by physician

Primary Care Physician(s) Name: _____

Primary Care Physician(s) Telephone Number: _____

Specialty Physicians: 1) _____ 2) _____ 3) _____

d/or Medical Problems:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

MEDICATIONS: None_____ Medication: _____ Frequency: _____ Route: _____
Medication: _____ Frequency: _____ Route: _____
Medication: _____ Frequency: _____ Route: _____
Medication: _____ Frequency: _____ Route: _____
Medication: _____ Frequency: _____ Route: _____

MEDICAL INFORMATION:

Problem(s):

_____
_____
_____
_____

Treatment Plan:

_____
_____
_____
_____

HOSPITALIZATIONS: Applicant's _____

_____

RESPIRATORY CARE (Applicant's): N/A:_____ Pulse Oximetry: _____CPT:_____ Trach Care: _____Suctioning/Frequency:_____
Is Recipient on O2? ☐ No ☐ Yes, if so: _____% Hours per Day _____
Ventilator ☐ During the Day # of Hours: _____ ☐ During the Night # of Hours _____
C-PAP or BI-PAP _____ Hours _____ ***(Please state)*** Day or Night _____

NUTRITIONAL THERAPY (Applicant's): Nutrition(s):_____ Oral/G-Tube/J-tube: _____
Frequency:_____ I.V. and/or TPN Information_____
Precautions: _____

EQUIPMENT: None_____Wheelchair_____Walking Devices_____Splints _____Other_____

CURRENT FUNCTIONAL STATUS: _____

_____

_____

_____

THERAPIES (Physical, Speech, Occupational, other) ***include frequency per week and attach therapy note*:**

_____

_____

_____

DMA – 706
11/04

RECOMMENDATIONS: _____

_____

_____

_____

LETTER OF MEDICAL NECESSITY (This must be written by the member's Physician)

_____

_____

_____

_____

_____ _____

Parent or Guardian/ Caregiver Signature/Primary Date

_____ _____

Physician Signature/Primary Date

_____ _____

Parent or Guardian/Caregiver Signature (Secondary) Date

_____ _____

Social Worker or /DFCS Foster Care Worker Date

This document requires at least two signatures, the primary care physician or physician of record and parent or guardian's (caregiver's signature).

** **Foster care Applicants must have the signature of the DFCS representative.**

TEFRA/KATIE BECKETT CARE PLAN INSTRUCTIONS FOR COMPLETION

This section provides detailed instructions for completion of the TEFRA/Katie Beckett Care Plan

SECTION A:

Section identifying information – This section should be completed by the parent or guardian

The (DFCS) will see that Section A is completed correctly.

The caseworker in the (DFCS) office will complete the address for the county office.

Complete **Date of TEFRA/Katie Beckett Waiver - Medicaid Application**
Enter the applicant's, mother's maiden name, and the date of Medicaid application.

Complete **Applicant's Name and Address**
Enter the complete name and address of the applicant including the zip code and county.

Medicaid Identification Number

Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;

b. If the member or applicant was previously determined eligible by DFCS staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or

c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

Applicant's Family History

Enter the name of the applicant's parents or legal guardian. Enter information regarding parent's or legal guardian's work history.
Enter information on the number of siblings in applicant's family.

School Services/Education

Does the applicant attend school?
Please check the appropriate box if the applicant attends school.

Is there an Individualized Family Service Plan (IFSP) or Individualized Educational Plan (IEP)?
Complete information regarding Level of Care on school, therapies.

Complete information regarding therapies received in school.

SECTION B:

Section Medical Information – This section must be completed by the Physician

Please enter the name of the primary care physician for the applicant. If a specialty physician is applies, enter that physician(s) name (s) also.

Applicant's detailed medical history. (Medical records or Transfer Record may be Attached).

Applicant's Diagnosis; Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition in the appropriate lines.

List **medications** and information regarding dosage type & frequency.
Names of drugs with dosages, routes, and frequencies of administration are to be included.

Diagnosis and treatment procedures required.
Medical Information problems - treatment plan
Hospital, history
Nutritional history
Equipment needs

- Current Functional Status - Is applicant ambulatory if applicable, etc.
- Therapies required. Physician's order must accompany therapies.
- Physician's goals and recommendations (Should be stated clearly).
- Physician's Letter of Medical Necessity (Should state the reason why the applicant qualifies for the TEFRA – medical documentation required.

Signatures

- Complete the date the application was signed by physician.
- Enter the date that the attending or admitting physician signs the form.
- Complete the date the application was signed by parent or legal guardian.
- Complete the date the application was signed by Social Service Child Protection worker (SSCM), if the child is in state custody.

TEFRA/KATIE BECKETT RETURN TO DFCS LETTER

Dear DFCS:

Enclosed are the name(s) of applicant(s) for the TEFRA/Katie Beckett that were submitted to GMCF for review. After review of the applications we found that some documents are missing. Please see enclosed checklist and return application(s) with the missing documents.

RE: Missing Documents

- ☐ DMA-6 (A) Form
- ☐ Physician letters of medical necessity
- ☐ Care Plan
- ☐ Psychological Assessment
- ☐ Current Rehab Therapy Notes
- ☐ Individualized Family Service Plan (IFSP)
- ☐ Individualized Education Plan (IEP)
- ☐ Other:_____

Return to:

Medicaid Worker's Name: _____ Caseload #:_____

Telephone #:_____ Email address:_____

Medicaid Worker's Address:_____

City: _____ State_____ Zip Code:_____

RE: Child's Name:_____

Child's Medicaid Member ID #:_____

Child's Social Security #:_____

_____ _____

Completed by GMCF Nurse Reviewer Date

Form DMA 703 TEFRA/Katie Beckett Return to DFCS Letter

TEFRA/KATIE BECKETT
Cost-Effectiveness Form
(Child's Physician Must Complete Form)

The following information is requested for the purpose of determining your patient's eligibility for Medicaid:

Patient's Name _____ Medicaid #:_____

Diagnosis: _____

Prognosis: _____

Please provide the estimated **monthly** costs of Medicaid services your patient will need or is seeking for Medicaid to cover for in-home care:

- Physician's services $_____
- Durable medical equipment $_____
- Drugs $_____
- Therapy(s) $_____
- Skilled nursing services $_____
- Other(s)_____ $_____

TOTAL: $_____

Will home care be as good or better than institutional care? _____Yes _____No

COMMENTS: _____

_____

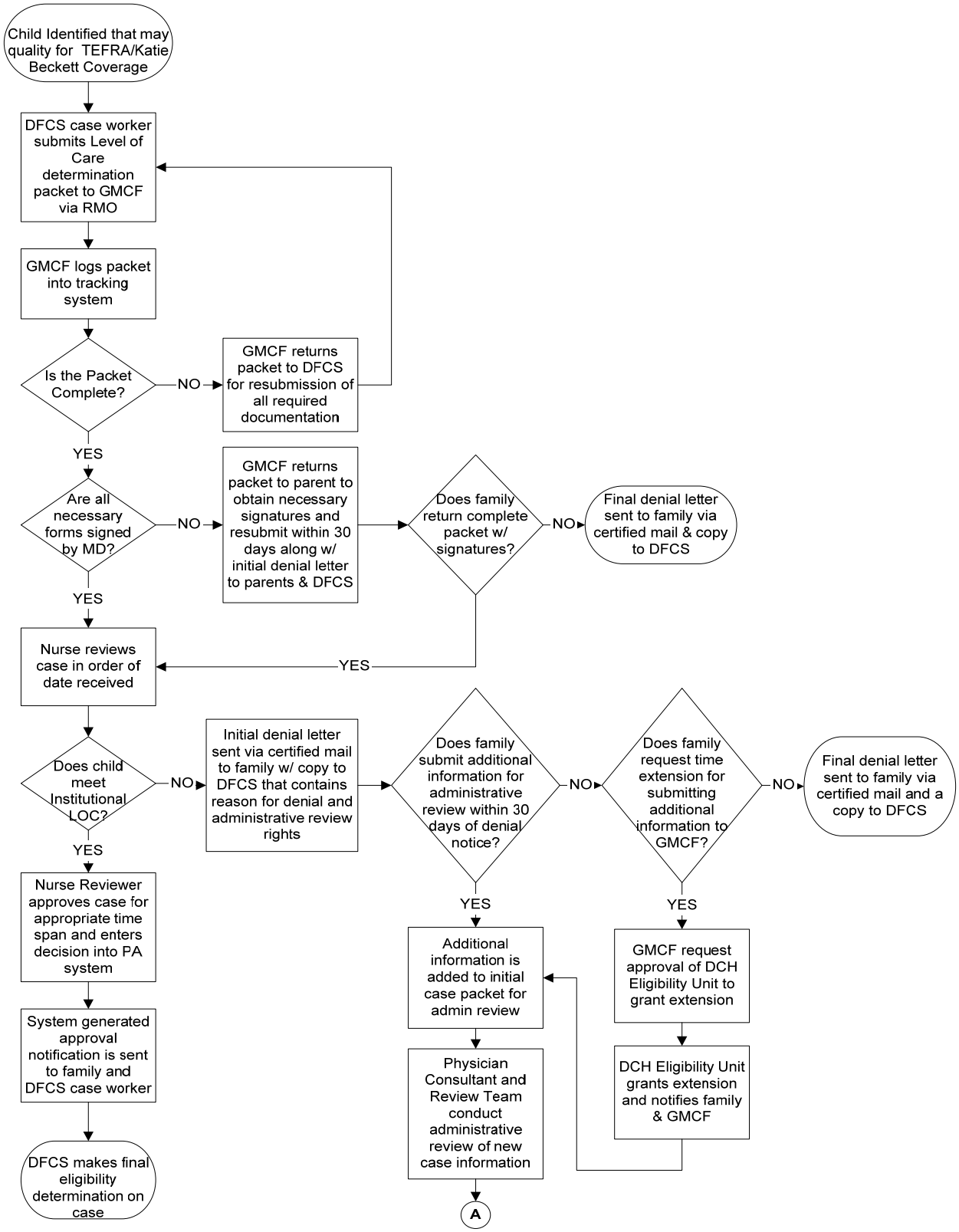
_____

_____

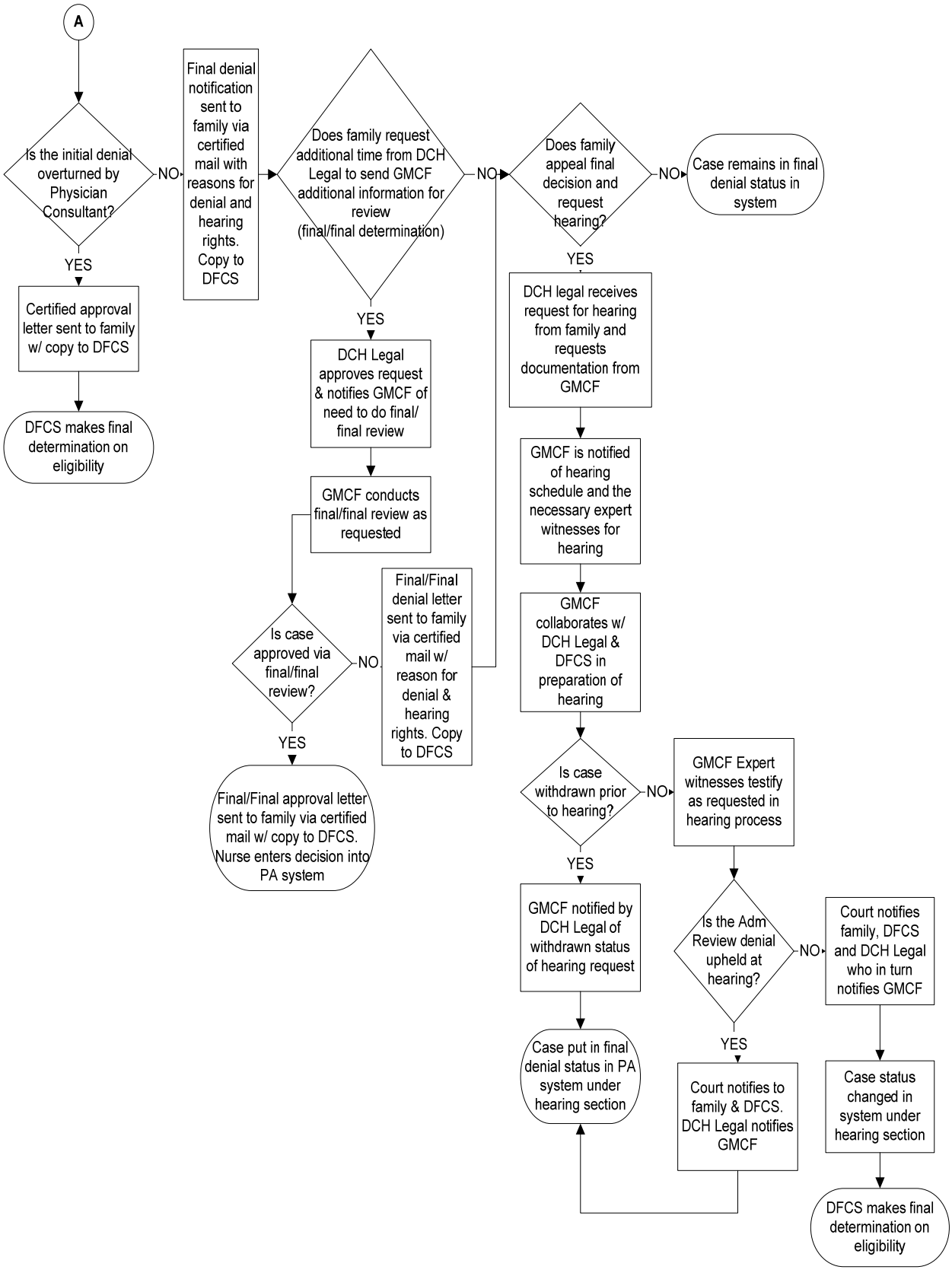
PHYSICIAN'S SIGNATURE: _____

DATE: _____

Application and LOC Review Process
(Flow Charts)



Application and LOC Review Process
(Flow Charts)



Georgia Health Partnership
1455 Lincoln Parkway, East
Suite 750
Atlanta, Georgia 30346-2200

Date

Parent/Legal Guardian Name
Address

RE: Child's Name (SS#)

Application Status: Initial or Continued Stay

INITIAL DENIAL OF ADMISSION OR CONTINUED SERVICES

Dear Parent/Legal Guardian of _____:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or hospital or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 CFR § 409.33, 440.10 and 440.150.

The Georgia Health Partnership (GHP), agent for with the Department of Community Health, makes the level of care determination based on the information submitted. (*Child's name*) does not meet criteria for the TEFRA/Katie Beckett because:

____ The child does not require daily skilled/professional nursing services because his/her condition is not so inherently complex that care cannot be safely and effectively performed by unskilled healthcare personnel as evidenced by: _____
_____
_____
_____

____ The child's condition does not meet hospital inpatient-qualifying criteria which necessitate:
____ Nursing interventions every 4-8 hours,
____ post critical care or weaning monitoring,
____ procedures/interventions which require hospitalization/interventions or
____ IV medications which require hospitalization

____ Services for this child are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 409.31-409.34 as evidenced by:_____
_____
_____

____ Rehabilitative services are not required five days per week per documentation submitted which is requirement of 42 CFR 409.31-409.34.

____ Your child has a diagnosis of mental retardation, cerebral palsy, epilepsy, or a condition that is closely related to mental retardation, but health and rehabilitative services are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 440.150, 435.1009 and 483.440(a).

____ Other: _____

_____

In accordance with the 42 CFR δ 435.225, your request for long-term care services under the Georgia Medicaid program will be denied unless additional medical information can justify the need for institutional care.

You may obtain a review of this decision by sending additional detail clinical information from your child's physician within thirty (30) days from the date of this letter. Please contact your local Department of Family and Children Services, attending physician, or your original referring agency if you need help with your request. All information must be submitted to the following address:

Georgia Health Partnership
Attention: "TEFRA/Katie Beckett Review Nurse"
1455 Lincoln Parkway, East
Suite 750
Atlanta, Georgia 30346-2200
Fax number: 678.527.3001

The Department will review the additional information and issue a Final Determination letter regarding your child's level of care determination.

Sincerely,

Katie Beckett Review Nurse
Georgia Health Partnership

cc: _____ County DFCS

Georgia Health Partnership
1455 Lincoln Parkway, East
Suite 750
Atlanta, Georgia 30346-2200

Date

Parent/Legal Guardian Name
Address

RE: Child's Name (SS#)

Application Status: Initial or Continued Stay

FINAL DENIAL OF ADMISSION OR CONTINUED STAY

Dear Parent/Legal Guardian of _____:

To receive TEFRA/Katie Beckett coverage care under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or a hospital, or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 CFR § 409.33, 440.10 and 440.150.

The Georgia Health Partnership (GHP), on behalf of the Georgia Department of Community Health (DCH), Division of Medical Assistance, has:

- reviewed the **new supplementary medical information submitted by you** or
- not received any additional medical information from you.

This letter is to notify you that based on our **reevaluation,** the initial decision is being upheld for (*child's name*) because:

____ Your child has a diagnosis of mental retardation, cerebral palsy, epilepsy, or a condition that is closely related to mental retardation, but health and rehabilitative services are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 440.150, 435.1009 and 483.440(a).

____Other:_____

____The child does not require daily skilled/professional nursing services because his/her condition is not so inherently complex that care cannot be safely and effectively performed by unskilled health care personnel as evidenced by: _____

_____

_____

_____

____The child's condition does not meet hospital inpatient-qualifying criteria which necessitate:
____ Nursing interventions every 4-8 hours,
____ post critical care or weaning monitoring,
____ procedures/interventions which require hospitalization/interventions or
____ IV medications which require hospitalization

____Services for this child are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 409.31-409.34 as evidenced by: _____
_____
_____

____Rehabilitative services are not required five days per week per documentation submitted, which is requirement of 42 CFR 409.31-409.34.

In accordance with 42 CFR δ 435.225 your request for long-term services under the Georgia Medicaid program is denied. If you disagree with this denial, you may request a fair hearing. To have a hearing, you must ask for one in writing in 30 days or less from the date of this letter. An explanation of your hearing rights is attached to this letter.

If you are currently receiving services you may also request that the Department maintain your services at the current level pending the outcome of your hearing. If the Administrative Law Judge rules in favor of the Department, the Department will seek reimbursement for services rendered during the appeal period.

If you are challenging the Department's "level of care" determination, please send your written request for hearing to:

Georgia Department of Community Health
Legal Services
2 Peachtree Street, NW-40th Floor
Atlanta, GA 30303-3159

If you want a hearing for any reason other than for the level of care determination, please send your written request to your local DFCS office.

Please attach this letter to your request for hearing.

Sincerely,

Medical Director, Katie Beckett Waiver
Georgia Health Partnership

cc: _____ County DFCS

Georgia Health Partnership
1455 Lincoln Parkway, East
Suite 750
Atlanta, Georgia 30346-2200

(PHYSICIAN NON-CERTIFICATION OF LOC)
PSYCHIATRIC CONDITION)

Date

Parents Name
Address
City, State, Zip

RE: Member Name (SS#)

Application Status: Initial or Continued Stay

INITIAL DENIAL OF ADMISSION OR CONTINUED SERVICES

Dear Parent/Legal Guardian of «Member_Name»:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or hospital or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 CFR § 409.33, 440.10 and 440.150.

The Georgia Health Partnership (GHP), agent for with the Department of Community Health, makes the level of care determination based on the information submitted. «Member_Name» does not meet criteria for the TEFRA/Katie Beckett **because the physician failed to certify that** «Member_Name» **requires the level of care provided by a nursing facility or hospital, therefore,** «Member_Name» **does not meet TEFRA/Katie Beckett criteria.**

In accordance with the 42 CFR δ 435.225, your request for long-term care services under the Georgia Medicaid program will be denied unless additional medical information can justify the need for institutional care. Attached is a copy of the Level of Care Criteria used for this determination for your review.

You may obtain a review of this decision by sending **documentation from your child's physician that he/she is certifying that** «Member_Name» **meets the required level of care provided by a nursing facility or hospital within thirty (30) days from the date of this letter (see number 25 of DMA-6A form or number 18 on DMA-6 form)**. **Please resubmit the entire packet to us once the requested documents are obtained.** Please contact your local Department of Family and Children Services, attending physician, or your original referring agency if you need help with your request.

All information must be submitted to the following address:

Georgia Health Partnership
Attention: "TEFRA/Katie Beckett Review Nurse"
1455 Lincoln Parkway, East
Suite 750
Atlanta, Georgia 30346-2200
Fax number: 678.527.3001

The Department will review the additional information and issue a Final Determination letter regarding your child's level of care determination.

Sincerely,

Katie Beckett Review Nurse

cc: «County_DFCS» County DFCS

Georgia Health Partnership
1455 Lincoln Parkway, East
Suite 750
Atlanta, Georgia 30346-2200

(PHYSICIAN NON-CERTIFICATION OF LOC)

Dear

Parent/Legal Guardian Name
Address

RE: Child's Name (SS#)

Application Status: Initial or Continued Stay

FINAL DENIAL OF ADMISSION OR CONTINUED STAY

Dear Parent/Legal Guardian of _____:

To receive TEFRA/Katie Beckett coverage care under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or a hospital, or if the child is mentally retarded, *(he/she)* must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 CFR § 409.33, 440.10 and 440.150.

The Georgia Health Partnership (GHP), on behalf of the Georgia Department of Community Health (DCH), Division of Medical Assistance, has **not** received any additional medical information from you. This letter is to notify you that based on our **re-evaluation,** the initial decision is being upheld for *(child's name* **because the physician failed to certify that** *(child's name* **requires the level of care provided by a nursing facility or hospital, therefore,** *(child's name* **does not meet TEFRA/Katie Beckett criteria.**

In accordance with 42 CFR δ 435.225 your request for long-term services under the Georgia Medicaid program is denied. If you disagree with this denial, you may request a fair hearing. To have a hearing, you must ask for one in writing in 30 days or less from the date of this letter. An explanation of your hearing rights is attached to this letter.

If you are currently receiving services you may also request that the Department maintain your services at the current level pending the outcome of your hearing. If the Administrative Law Judge rules in favor of the Department, the Department will seek reimbursement for services rendered during the appeal period.

If you are challenging the Department's "level of care" determination, please send your written request for hearing to:

Georgia Department of Community Health
Legal Services
2 Peachtree Street, NW-40th Floor
Atlanta, GA 30303-3159

If you want a hearing for any reason other than for the level of care determination, please send your written request to your local DFCS office.

Please attach this letter to your request for hearing.

Sincerely,

Harrison Rogers, M.D.
Medical Director, Katie Beckett Waiver
Georgia Health Partnership

cc: County DFCS

PRIMARY PSYCHIATRIC CONDITION

Georgia Health Partnership
1455 Lincoln Parkway, East
Suite 750
Atlanta, Georgia 30346-2200

Date

Parents Name
Address
City, State, Zip Code

RE: Member Name (SS#)

☐ Initial Application ☐ Continued Stay Application

INITIAL DENIAL OF ADMISSION

Dear Parent/Legal Guardian of Member Name:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or hospital or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). "**Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services ordinarily provided in an institution."** *See* 42 CFR § 409.31-409.34 **"Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases."** *See* 42 CFR § 440.10 **"ICFMR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions."** *See* 42 CFR § 440.150, 435.1009 and 483.440(a).

The Georgia Health Partnership (GHP), agent for the Department of Community Health, makes the determination of medical necessity for admission to a nursing facility, hospital or an ICFMR. Member Name does not meet criteria for the TEFRA/Katie Beckett because:

_____ Based on a review of your son's/daughter's record, «Member_Name» has psychiatric and psychological needs which require monitoring by a healthcare professional; however,

his/her case is strictly psychiatric in nature. A child is not considered appropriate for nursing facility, intermediate (ICFMR), or hospital level of care services when the primary diagnosis or the primary needs of the patient are psychiatric rather than physical or non-psychiatric as evidenced by the following:

- _____
- _____
- _____

_____ The child does not require daily skilled/professional nursing services because his/her condition is not so inherently complex that care cannot be safely and effectively performed by unskilled healthcare personnel as evidenced by documentation submitted which states:

-
-

_____ The child's condition does not meet hospital inpatient-qualifying criteria which necessitate:

_____ nursing interventions every 4-8 hours,
_____ post critical care or weaning monitoring,
_____ procedures/interventions which require hospitalization/interventions or
_____ IV medications which require hospitalization.

_____ Services for this child are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 409.31-409.34 as evidenced by previous documentation.

_____ Rehabilitative services are not required five days per week per documentation submitted which is requirement of 42 CFR 409.31-409.34. A child must meet institutional level of care and be in an aggressive program of skills acquisition at the time of application to meet the CFR requirements.

_____ Your child has a diagnosis of mental retardation, cerebral palsy, epilepsy, or a condition that is closely related to mental retardation, but health and rehabilitative services are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 440.150, 435.1009 and 483.440(a).

_____ Other: _____
_____
_____
_____
_____

This letter is to notify you that based on the information submitted, «Member_Name» does not meet criteria for the TEFRA/Kathie Beckett and in accordance with the 42 CFR § 435.225, and your request for long-term care services under the Georgia Medicaid program is denied. I recommend you work with your Regional Board of Mental Health regarding placement of your son/daughter in a mental health program. Please see the attached list which provides your point of contact for the Regional Board of Mental Health for the county in which your child resides.

In accordance with the 42 CFR § 435.225, your request for long-term care services under the Georgia Medicaid program will be denied unless additional medical information can justify the need for institutional care. Attached is a copy of the Level of Care Criteria used for this determination for your review.

You may obtain a review of this decision by sending additional detailed clinical information from your child's physician within thirty (30) days from the date of this letter. Please contact your local Department of Family and Children Services, attending physician, or your original referring agency if you need help with your request. All information must be submitted to the following address:

Georgia Health Partnership
Attention: "TEFRA/Katie Beckett Review Nurse"
1455 Lincoln Parkway, East
Suite 750
Atlanta, Georgia 30346-2200
Fax number: 678.527.3001

The Department will review the additional information and issue a Final Determination letter regarding your child's level of care determination.

Sincerely,

_____, RN
Katie Beckett Review Nurse

cc: _____, Medicaid Worker
«County_DFCS» County DFCS

PRIMARY PSYCHIATRIC CONDITION

Georgia Health Partnership
1455 Lincoln Parkway, East
Suite 750
Atlanta, Georgia 30346-2200

Date

Parents Name
Address
City, State, Zip Code

RE: Member Name (SS#)

Dear Parent/Legal Guardian of Member Name:

FINAL DENIAL OF ADMISSION OR CONTINUED STAY

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or hospital or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). "**Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services ordinarily provided in an institution."** *See* 42 CFR § 409.31-409.34 **"Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases."** *See* 42 CFR § 440.10 **"ICFMR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions."** *See* 42 CFR § 440.150, 435.1009 and 483.440(a).

The Georgia Health Partnership (GHP), on behalf of the Georgia Department of Community Health (DCH), Division of Medical Assistance, has:

- reviewed the **new supplementary medical information submitted by you** or
- not received any additional medical information from you.

Member Name does not meet criteria for the TEFRA/Katie Beckett because:

____ Based on a review of your son's/daughter's record, «Member_Name» has psychiatric and psychological needs which require monitoring by a healthcare professional; however, his/her case is strictly psychiatric in nature. A child is not considered appropriate for nursing facility,

intermediate (ICFMR), or hospital level of care services when the primary diagnosis or the primary needs of the patient are psychiatric rather than physical or non-psychiatric as evidenced by the following:

- o _____
- o _____
- o _____

_____ The child does not require daily skilled/professional nursing services because his/her condition is not so inherently complex that care cannot be safely and effectively performed by unskilled healthcare personnel as evidenced by documentation submitted which states:

- •
- •

_____ The child's condition does not meet hospital inpatient-qualifying criteria which necessitate:

_____ nursing interventions every 4-8 hours,
_____ post critical care or weaning monitoring,
_____ procedures/interventions which require hospitalization/interventions or
_____ IV medications which require hospitalization.

_____ Services for this child are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 409.31-409.34 as evidenced by previous documentation.

_____ Rehabilitative services are not required five days per week per documentation submitted which is requirement of 42 CFR 409.31-409.34. A child must meet institutional level of care and be in an aggressive program of skills acquisition at the time of application to meet the CFR requirements.

_____ Your child has a diagnosis of mental retardation, cerebral palsy, epilepsy, or a condition that is closely related to mental retardation, but health and rehabilitative services are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 440.150, 435.1009 and 483.440(a).

_____ Other: _____

_____

_____

_____

This letter is to notify you that based on the information submitted, he/she does not meet criteria for the TEFRA/Katie Beckett and in accordance with 42 CFR δ 435.225 your request for long-term services for your child under the Georgia Medicaid program is denied. I recommend you work with your Regional Board of Mental Health regarding placement of your son/daughter in a mental health program. Please see the attached list which provides your point of contact for the Regional Board of Mental Health for the county in which your child resides.

If you disagree with this denial, you may request a fair hearing. To have a hearing, you must ask for one in writing in 30 days or less from the date of this letter. An explanation of your hearing rights is attached to this letter.

If you are currently receiving services you may also request that the Department maintain your services at the current level pending the outcome of your hearing. If the Administrative Law Judge rules in favor of the Department, the Department will seek reimbursement for services rendered during the appeal period.

If you are challenging the Department's "level of care" determination, please send your written request for hearing to:

Georgia Department of Community Health
Legal Services
2 Peachtree Street, NW-40th Floor
Atlanta, GA 30303-3159

If you want a hearing for any reason other than for the level of care determination, please send your written request to your local DFCS office.

Please attach this letter to your request for hearing.

Sincerely,

_____, RN
Katie Beckett Review Nurse

cc: _____, Medicaid Worker
«County_DFCS» County DFCS

Medical Director, Katie Beckett Waiver
Georgia Health Partnership

cc: «County_DFCS» County DFCS

Level of care criteria are based on definitions and guidelines derived from the Federal regulations and are used to assist assessors in evaluating clinical information submitted.

PEDIATRIC

NURSING FACILITY LEVEL OF CARE

Summary:

1. Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or Other health-related services *ordinarily provided in an institution*. With respect to an individual who has a mental illness or mental retardation, nursing facility level of care services Are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.
2. The criteria set forth herein encompass both "skilled" and "intermediate" levels of care services.
3. A nursing facility level of care is indicated if the conditions of Column A are satisfied in addition to the conditions of Column B being satisfied. Conditions are derived from 42 C.F.R. 409.31 – 409.34.
4. Some examples of those cases which meet Nursing Facility Level of Care Criteria are as follows:
    a. Severely Medical Fragile Child as they will meet the criteria in Column A, 1, and I,2, b and possibly others under 2 depending on the individual child plus Column B.
    b. Child with Cystic Fibrosis if they are receiving oxygen 5-7 days a week intermittently or continuously and/or the child has to be hospitalized 3-4 times per year for Cystic Fibrosis exacerbations which will meet the criteria in Column A, 1, and I, 2, b, j and Column B.
    c. Child with Osteogensis Imperfecta Type 2 and 3. A child with Type 2 has the most severe form which is frequently lethal and the child has numerous fractures with severe bone deformity. Type 3 has bones that fracture easily and possible respiratory problems. This child will meet the criteria in Column A, 1, and 2, b, k and II (possibly a-e) and Column B.
    d. Child who is medically unstable awaiting organ transplant and/or is in post-op period for one year post transplant. This child will meet the criteria in Column A,
    1, and I, 2, b, and possibly others under 2 depending on the individual child plus Column B. This child will meet hospital level of care while in hospital for transplant. Once the child is stable post transplant he/she no longer meets nursing facility level of care criteria.
    e. Children born at 26 weeks or less gestation. These children are at high risk of complications due to prematurity and are in the NICU at the beginning of life. These children would meet hospital level of care criteria while hospitalized and nursing facility level of care once discharged. The child will meet multiple criteria in Column A and B depending on the medical needs of the child and will initially be approved for only six months and then re-evaluated.
    f. Child with Hemophilia: who is receiving IV Factor 8 on a 2-3 times/month schedule; or who has documented antibodies to Factor 8 (high risk for bleeding); or who exhibits chronic joint syndrome or a head bleed which requires an aggressive rehabilitation program. The child will meet multiple criteria in Column A and
    B depending on the medical needs of the child.
    g. Child with Sickle Cell: who is receiving chronic transfusions of 1-2 per month; or is admitted to the hospital with acute chest syndrome 2 or more times per year; or who is in pain crisis requiring hospitalization 3 or more times per year; or who has had a stroke and is involved in an aggressive rehabilitation program The child will meet multiple criteria in Column A and B depending on the medical needs of the child.

Revised 1-06, 2/06

COLUMN A		COLUMN B
	II.	
1. The individual requires service which is so inherently complex that it can be safely and effectively performed only	2. The service is one of the following or similar and is required five days per	1. The service needed has been ordered by a

by, or under the supervision of,
technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, and speech pathologists or audiologists,

AND

In addition to the condition listed above, one of the following subparts of #2 must be met:

I.

2. The service is one of the following or similar and is required seven days per week:
   a. Overall management and evaluation of a care plan for an individual who is totally dependent in all activities of daily living
   b. Observation and assessment of an individual's changing condition because the documented instability of his or her medical condition is likely to result in complications, or because the documented instability of his or her mental condition is likely to result in suicidal or hostile behavior
   c. Intravenous or intramuscular injections or intravenous feeding
   d. Enterable feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day
   e. Nasopharyngeal or tracheostomy aspiration
   f. Insertion and sterile irrigation or replacement of suprapubic catheters
   g. Application of dressings involving prescription medications and aseptic techniques
   h. Treatment of extensive Decubiti ulcers or other widespread skin disorder
   i. Heat treatments as part of active treatment which requires observation by nurses
   j. Initial phases of a regimen involving administration of medical gases
   k. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment

OR

week:
   a. Ongoing assessment of rehabilitation needs and potential: services concurrent with the management of a patient care plan
   b. Therapeutic exercises and activities performed by PT or OT
   c. Gait evaluation and training to restore function to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality
   d. Range of motion exercises which are part of active treatment of a specific condition which has resulted in a loss of, or restriction of mobility
   e. Maintenance therapy when specialized knowledge and judgment is needed to design a program based on initial evaluation
   f. Ultrasound, short-wave, and microwave therapy treatment
   g. Hot pack, hydro collator, infrared treatments, paraffin baths, and whirlpool treatment when the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, etc. and specialized knowledge and judgment is required
   h. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing

OR

III

2. The service is one of the following only if an additional special medical complication requires that it be performed or supervised by technical or professional personnel:
   a. Administration of routine medications, eye drops, and ointments.
   b. General maintenance care of colostomy or ileostomy
   c. Routine services to maintain satisfactory functioning of indwelling bladder catheters
   d. Changes of dressings for non-infected postoperative or chronic conditions
   e. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems
   f. Routine care of incontinent individuals, including use of diapers and protective sheets
   g. General maintenance care (e.g. in connections with a

physician.
2. The service will be furnished either directly by, or under the supervision of, appropriately licensed personnel.
3. *The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.*

	plaster cast) h. Use of heat as a palliative and comfort measure (e.g. whirlpool and hydrocollator) i. Routine administration of medical gases after a regimen of therapy has been established j. Assistance in dressing, eating, and toileting k. Periodic turning and positioning of patients. l. General supervision of exercises that were taught to the individual and can be safely performed by the individual including the actual carrying out of maintenance programs	

INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE

Summary:

1. ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.
2. An ICF/MR level of care is generally indicated if one condition of Column A is satisfied in addition to the conditions Column B and Column C being satisfied. Conditions derived from 42 C.F.R. 440.150, 435.1009, and 483.440(a).
3. Column B refers to "an aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services." These active treatment services, as defined in 42 C.F.R. 483.440, provide aggressive, consistent monitoring, supervision and/or assistance as defined in the plan of care to address the specific medical conditions, developmental and behavioral needs, and/or functional limitations identified in the comprehensive functional assessment. This comprehensive functional assessment must be age appropriate.
4. The following conditions meet ICF/MR institutional level of care criteria, as these individuals would be institutionalized regardless of ability to participate in an aggressive program of specialized and generic training, treatment, health services, and related services as outlined in Column B:
   - Those children with an IQ of 50 or below (moderate to profound mental retardation) or
   - Those children who meet the criteria for Autism, Autism-Spectrum, Asperger's, Pervasive Developmental Disorder, Developmental Delay, Mental Retardation, Down's Syndrome, and any other Developmental Disability as evidenced by:
     i. a score on a standardized adaptive functioning tool of 2 standard deviations below the norm in three or more of any of the following behavior domains: self care skills, understanding and use of verbal and nonverbal language learning in communication with others, mobility, self-direction, and age-appropriate ability to live without extraordinary assistance or an overall standard score < 70, or
     ii. if their age equivalency composite score is less than 50% of their chronological age, and/or
     iii. the child has a Childhood Autism Rating Scale (CARS) score of above 37, a Gilliam Autism Rating Scale (GARS) of 121 or greater, or any other equivalent standardized assessment tool which indicate severe autism.

COLUMN A (Diagnosis)	COLUMN B (Plan of Care)	COLUMN C (Functional Need)
1. The individual has mental retardation. OR 2. The individual has a severe chronic disability attributable to cerebral palsy or epilepsy. OR 3. The individual has a condition, *other than mental illness*, (i.e. Autism, Autism-spectrum, Asperger's, Pervasive Developmental Disorder, Down's Syndrome or Developmental Delay) which is found to be closely related to mental retardation because it is likely to last indefinitely, and requires similar treatment and services. AND 4. The impairment for those conditions outlined above constitutes an impairment of general intellectual functioning, and results in substantial limitations in three or more of the following functional limitations: • Self-care skills such as feeding, toileting, dressing and bathing; • Understanding and use of verbal and nonverbal language learning in communication with others; • Mobility; • Self-direction in managing one's social and personal life and the ability to make decisions necessary to protect one's self as per age-appropriate ability; and/or • Age-appropriate ability to live without extraordinary assistance.	On a continuous basis, the individual requires aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services which is directed towards- a. The acquisition of the skills necessary for the individual to function with as much self-determination and independence as possible; and b. The prevention of further decline of the current functional status or loss of current optimal functional status. This is evidenced in the Plan of Care by the individual's participation (at least five (5) days a week) in interventions which are required to correct or ameliorate the conditions/diagnosis; and are compatible with acceptable professional practices in light of the condition(s) at the time of treatment. Active treatment does not include: • interventions that address age-appropriate limitations; or • general supervision of children whose age is such that supervision is required by all children of the same age or • physical assistance for persons who are unable to physically perform tasks but who understand the process needed to do them	1. The services have been ordered by a licensed physician. AND 2. The services will be furnished either directly by, or under the supervision of, appropriately qualified providers (see definitions): AND 3. The services, as a practical matter, would have ordinarily been provided in an ICF-MR, in the absence of community services. *Revised 3/3/06*

Revised 3/3/06

HOSPITAL LEVEL OF CARE

Summary:

1. Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases.
2. A hospital level of care is indicated if the conditions of Column A, Column B, and Column C are satisfied. Conditions derived from 42 C.F.R 440.10.

COLUMN A	COLUMN B	COLUMN C
1. The individual has a condition for which room, board, and professional services furnished under the direction of a physician or dentist is expected to be medically necessary for a period of 48 hours or longer. 2. The professional services needed are something other than nursing facility and ICF/MR services.	The individual's condition meets inpatient level of care.	1. The service needed has been ordered by a physician or dentist. 2. The service will be furnished either directly by, or under the supervision of, a physician or dentist. 3. The service is ordinarily furnished, as a practical matter, in an appropriately licensed institution for the care and treatment of patients with disorders other than mental diseases.

NURSING FACILITY LEVEL OF CARE — *COLUMN A*	**EXPLANATIONS**
	42 CFR 409.31-409.34
	I.
1. The individual requires service which is so inherently complex that it can be safely and effectively performed only by, or under the supervision of, technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, and speech pathologists or audiologists. In addition to the condition listed above, one of the following subparts of #2 must be met:	1. Definition. As used in this section, skilled nursing and skilled rehabilitation services means services that: (1) Are ordered by a physician; (2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and (3) Are furnished directly by, or under the supervision of, such personnel.
I.	
2. The service is one of the following or similar and is required seven days per week:	2. Specific conditions for meeting level of care requirements. (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.
2 a. Overall management and evaluation of a care plan for an individual who is totally dependent in all activities of daily living	2. a. Services that could qualify as either skilled nursing or skilled rehabilitation services--(1) Overall management and evaluation of care plan. (i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel. (ii) Example. An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one

	service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled.
2. b. Observation and assessment of an individual's changing condition because the documented instability of his or her medical condition is likely to result in complications, or because the documented instability of his or her mental condition is likely to result in suicidal or hostile behavior.	2. b. Observation and assessment of the patient's changing condition-- (i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized. (ii) Examples. A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. Similarly, surgical patients transferred from a hospital to an SNF while in the complicated, unutilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or *Contract #500-99-0009/0003 DynCorp Therapy PSC Page 204 of 1201 Deliverable # 25 – Dissemination of Educational Materials 30 November 2001TRP Compilation of National Part B Therapy Policy* hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes.
2. c. Intravenous or intramuscular injections or intravenous feeding	2. c. Services that qualify as skilled nursing services. (1) Intravenous or intramuscular injections and intravenous feeding.
2. d. Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day	2. d. Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day.
2. e. Nasopharyngeal or tracheostomy aspiration	2. e. Nasopharyngeal and tracheostomy aspiration;
2. f. Insertion and sterile irrigation or replacement of suprapubic catheters	2. f. Insertion and sterile irrigation and replacement of suprapubic catheters;
2. g. Application of dressings involving prescription medications and aseptic techniques	2. g. Application of dressings involving prescription medications and aseptic techniques;
2. h. Treatment of extensive decubitis ulcers or other widespread skin disorder	2. h. Treatment of extensive decubitus ulcers or other widespread skin disorder;
2. i. Heat treatments as part of active treatment which requires observation by nurses	2. i. Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

2. j. Initial phases of a regimen involving administration of medical gases	2. j. Initial phases of a regimen involving administration of medical gases;
2. k. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment	2. k. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.
OR	
II.	**EXPLANATIONS** **II.**
2. The service is one of the following or similar and is required five days per week:	2. To meet the daily basis requirement specified in Sec. 409.31(b)(1), the following frequency is required: - Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or - As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week. - A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.
2. a. Ongoing assessment of rehabilitation needs and potential concurrent with the management of a care plan	2. a. Services which would qualify as skilled rehabilitation services. (1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders.
2. b. Therapeutic exercises and activities performed by PT or OT	2. b. Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment.
2. c. Gait evaluation and training to restore function to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality	2. c. Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality.
2. d. Range of motion exercises which are part of active treatment of a specific condition which has resulted in a loss of, or restriction of mobility	2. d. Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored).
2. e. Maintenance therapy when specialized knowledge and judgment is needed to design a program based on initial evaluation	2. e. Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance

	program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the *Contract #500-99-0009/0003 DynCorp Therapy PSC Page 205 of 1201Deliverable # 25 – Dissemination of Educational Materials 30 November 2001 TRP Compilation of National Part B Therapy Policy* services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.
2. f. Ultrasound, short-wave, and microwave therapy treatment	2. f. Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;
2. g. Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool treatment when the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, etc. and specialized knowledge and judgment is required	2. g. Hot pack, hydrocollator, infrared treatments, paraffin baths, and .whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required**.**
2. h. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing **OR**	2. h. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.
III. **2.** ***The service is one of the following only if an additional special medical complication requires that it be performed or supervised by technical or professional personnel:***	**EXPLANATIONS** III. 2. A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in Sec. 409.33 (d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust

2. a. Administration of routine medications, eye drops, and ointments. 2. b. General maintenance care of colostomy or ileostomy 2. c. Routine services to maintain satisfactory functioning of indwelling bladder catheters 2. d. Changes of dressings for non-infected postoperative or chronic conditions 2. e. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems 2. f. Routine care of incontinent individuals, including use of diapers and protective sheets 2. g. General maintenance care (e.g. in connections with a plaster cast) 2. h. Use of heat as a palliative and comfort measure (e.g. whirlpool and hydrocollator) 2. i. Routine administration of medical gases after a regimen of therapy has been established 2. j. Assistance in dressing, eating, and toileting 2. k. Periodic turning and positioning of patients. 2. l. General supervision of exercises that were taught to the individual and can be safely performed by the individual including the actual carrying out of maintenance programs. General supervision of exercises that were taught to the individual and can be safely performed by the individual including the actual carrying out of maintenance programs, **OR**	traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes. 2. a. Administration of routine oral medications, eye drops, and ointments; 2. b. General maintenance care of colostomy and ileostomy; 2. c. Routine services to maintain satisfactory functioning of indwelling bladder catheters. 2. d. Changes of dressings for noninfected postoperative or chronic conditions; 2. e. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems; 3. f. Routine care of the incontinent patient, including use of diapers and protective sheets; 2. g. General maintenance care in connection with a plaster cast; 2. h. Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator; 2. i. Routine administration of medical gases after a regimen of therapy has been established. 2. j. Assistance in dressing, eating, and going to the toilet; 2. k. Periodic turning and positioning in bed; and 2. l. General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

NURSING FACILITY LEVEL OF CARE - *COLUMN B*	EXPLANATIONS
1. The service needed has been ordered by a physician.	**IV. 42 CFR 409.31(a)(1)** **I.** 1. a. Definition. As used in this section, skilled nursing and skilled rehabilitation services means services that: (1) Are ordered by a physician; 42 CFR 409.31(a.)(2.)(3)
2. The service will be furnished either directly by or under the supervision of appropriately licensed personnel.	2. Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and Are furnished directly by, or under the supervision of, such personnel. **42 CFR 409.31(b) (3)**
3. The service is ordinarily furnished, as a practical matter, on an impatient basis.	3. The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis. **42 CFR 409.35** General considerations. In making a ``practical matter'' determination, as required by Sec. 409.31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare payment for those services may not be a factor. Example: The beneficiary can obtain daily physical therapy from a physical therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $500 of services furnished by such a practitioner in a year. This limitation on payment may not be a basis for finding that the needed care can only be provided in a SNF.

INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE — *COLUMN A*	**EXPLANATIONS** **42 CFR 435.1009**
I. 1. The individual has mental retardation. 2. The individual has a severe chronic disability attributable to cerebral palsy or epilepsy. 3. The individual has a condition, *other than mental illness*, which is found to be closely related to mental retardation because it is likely to last indefinitely, requires similar treatment and services, constitutes an impairment of general intellectual functioning, and results in substantial limitations in three or more of the following: self-care, understanding and use of language learning, mobility, self direction, and capacity for independent living.	**I.** 1. Institution for the mentally retarded or persons with related conditions means an institution (or distinct part of an institution) that: (a) Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions. 2. Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: It is attributable to cerebral palsy or epilepsy. ▪ It is manifested before the person reaches age 22. ▪ It is likely to continue indefinitely. ▪ It results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care. (2) Understanding and use of language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living. 3. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. ▪ It is manifested before the person reaches age 22. ▪ It is likely to continue indefinitely. ▪ It results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care. (2) Understanding and use of language. (3) Learning. (4) Mobility. (5) Self-direction.

	(6) Capacity for independent living.
INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE — *COLUMN B* 1. On a continuous basis, the individual requires aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services which is directed towards— a. The acquisition of the skills necessary for the individual to function with as much self-determination and independence as possible; and b. The prevention of further decline of the current functional status or loss of current optimal functional status.	**EXPLANATIONS** **42 CFR 483.440** 1. Standard: Active treatment. (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: a. The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and b. The prevention or deceleration of regression or loss of current optimal functional status.
INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE — *COLUMN C* 1. The service needed has been ordered by a physician. 2. The service will be furnished either directly by, or under the supervision of, appropriately licensed personnel.	**EXPLANATIONS** **42 CFR 483.460(a)(1-2)** 1. a. Standard: Physician services. (1) The facility must ensure the availability of physician services 24 hours a day. (2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires care ordinarily given on an inpatient basis. This plan must be integrated in the individual program plan. **42 CFR 483.430(a)(1-2)** 2. a. Standard: Qualified mental retardation professional. Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional who— (1) Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and (2) Is one of the following: - A doctor of medicine or osteopathy. - A registered nurse.

3. The service required is ordinarily furnished, as a practical matter, on an inpatient basis.	- An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b) (5) of this section. **42 CFR 483.460(a)(1-2)** 3. a. Standard: Physician services. (1) The facility must ensure the availability of physician services 24 hours a day. (2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires care ordinarily given on an inpatient basis. This plan must be integrated in the individual program plan.

HOSPITAL LEVEL OF CARE — *COLUMN A*	**EXPLANATIONS** **42 CFR 440.2**
1. The individual has a condition for which room, board, and professional services furnished under the direction of a physician or dentist is expected to be medically necessary for a period of 48 hours or longer. 2. The professional services needed are something other than nursing facility and ICF/MR services.	1. Receives room, board and professional services in the institution for a 24 hour period or longer. 2. Inpatient hospital services do not include SNF and ICF services furnished by a hospital with a swing-bed approval.
HOSPITAL LEVEL OF CARE — *COLUMN B*	
The individual's condition meets inpatient level of care.	
HOSPITAL LEVEL OF CARE — *COLUMN C*	**EXPLANATIONS** **42 CFR 440.2**
4. The service needed has been ordered by a physician and dentist. 5. The service will be furnished either directly by, or under the supervision of, a physician or dentist. 6. The service is ordinarily furnished, as a practical matter, in an appropriately licensed institution for the care and treatment of patients with disorders other than mental diseases.	1. Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist. 2. Inpatient hospital services means services that: a. Are ordinarily furnished in a hospital for the care and treatment of inpatients; b. Are furnished under the direction of a physician or dentist. 3. Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; (ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting.